LETTERS *to the Editor*

Responses to "A Call for Help"

TO THE EDITOR: This is a report on the response to my letter to the Editor in the September issue [Calif Med 117:82, Sep 1972], in which I asked why our fellow-physicians are apparently so reluctant to utilize psychiatric consultation for their patients.

In all, eight physicians have replied (so far). Of the eight respondents two are in public health, two in general practice, two in surgical specialty, one in pediatrics, and one apparently retired. The eight respondents listed the following reasons for which, they believe, physicians in general are reluctant to ask for a psychiatric consultation:

1. Psychiatrists are "aloof": they (a) don't come to staff meetings; (b) don't respond to emergencies; (c) are hard to reach ("how would you like to be told to call back exactly between 2:50 and 3:00 p.m.?").

2. Psychiatrists show poor manners in consultation: (a) don't report back to the referring doctor; (b) prescribe conflicting medications without having bothered to check with the referring doctor or having taken a medication history.

3. Psychiatry is unscientific: (a) it has many esoteric theories, few solid facts; (b) psychiatrists are divided among themselves and seem more interested in promoting their respective pet theories than in objective truth.

4. Psychiatrists are not very effective: (a) they can't even help with resolving conflicts among hospital staff; (b) instead of treating the patient themselves they tend to re-refer to some intern or other mental health worker; (c) contrary to what they preach, they too "label" the patient and treat *it* (the "disease") rather than relating to him as a total human being who has problems in living; (d) psychotherapy lasts forever and its results are difficult to measure quantitatively; (e) many patients seem to get not better but worse: after therapy they become more self-deprecatory and more dependent, or else more hostile and ornery than they already had been.

5. Psychiatry still has a "stigma": (a) patients are ashamed; (b) relatives are embarrassed; (c) insurance policies don't pay!

6. Physicians' prejudice: non-psychiatrists have become conditioned to treat everything with pills and potions and have little trust in anything less tangible.

How widely these opinions prevail among physicians is, of course, an open question; one could even get defensive and argue that they are obviously biased and objectively unjustified. All I can say at this time is that *if* such opinions do indeed prevail, that would explain the observations which prompted my inquiry in the first place. It would also point up the need for much work yet to be done to bridge this apparent gap between psychiatry and other branches of medicine.

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Actinobacillus Actinomycetemcomitans

TO THE EDITOR: I read with interest the article "Bacterial Endocarditis Due to Actinobacillus Actinomycetemcomitans in a Patient with a Prosthetic Aortic Valve" by Stauffer JL and Goldman MJ in CALIFORNIA MEDICINE (Calif Med 117:59-63, Aug 1972). The authors stated that there have only been eight prior cases reported of bacterial endocarditis secondary to this microorganism. However, in August, 1971, I co-authored a paper entitled "Infection Due to Actinobacillus Actinomycetemcomitans," Meyers BR, Bottone E, Hirschman SZ, Schneierson SS, Gershengorn K which appeared in Am J Clin Path 56:204-211, 1971. In this paper we reported another case of bacterial endocarditis in a patient without prior heart disease who responded to antimicrobial therapy. We also described the microbiology of these microorganisms and their antimicrobial sensitivity, both disc and tube dilution studies. The paper also described a case of septicemia in a patient with multiple myeloma.

This article is brought to your attention because we feel that the antimicrobial sensitivity studies may be helpful in future therapy of these microorganisms and to emphasize that an adept bacteriology laboratory is necessary to isolate and characterize these bacteria.

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